DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

February 20, 1990

ALL-COUNTY LETTER NO. 90-20

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
WORKER'S COMPENSATION INSURANCE

The California Worker's Compensation Reform Act of 1989 (AB 276 and SB 47) changed reporting procedures for employers effective January 1, 1990. Previously, the only requirement of the recipient/employer was to complete the Employer's First Report of Occupational Injury (SCIF Form 3167IHSS) and submit it to the State Compensation Insurance Fund within five days of the injury or occupational disease. Counties were to assist the recipients with this task, when necessary.

In order for the In-Home Supportive Services (IHSS) Program to comply with the new law, it is now necessary for the recipient/employer to not only complete the Employer's First Report of Occupational Injury but also to immediately provide the employee an Employee's Claim Form for Workers' Compensation Benefits (SCIF Form 3301) for the injured employee to complete. (See attached a copy of this 3 part form.)

A temporary supply of the Employee Claim for Workers' Compensation Benefits form is being sent under separate cover to each IHSS Program Manager. The claim form is important as it is to be given to the injured employee within one working day of the employer's knowledge of the injury.

The form should be completed as follows:

1. As soon as the employer is notified of the employee's injury, the injured employee must be given an Employee's Claim Form for Workers' Compensation Benefits and date the form in the space provided.

2. The completed form is then sent by the claimant to the County. The form must be dated again. The original copy of the form should be sent to the State Compensation Insurance Office designated for your County in the IHSS/CMIPS User's Manual, Section X-F.

3. The injured employee should keep a copy for him/herself and promptly submit the original copy to the County and the employer's copy to the recipient. It is recommended that the County also retain a photo copy in the case record. The employee should not wait for the doctor's or the employer's first report of injury before submitting the claim form to the County.

The Reform Act may require additional changes in the way the State administers Workers' Compensation procedures as they apply to the In-Home Supportive Services Program. DSS staff will be meeting with the State Compensation Insurance Fund and the State Office of Insurance and Risk Management to develop these procedures. Once this has been done, Counties will be notified of the changes and new procedures, if any, in a change to the IHSS/CMIPS User's Manual, Section X-F. In the interim, Counties should continue to assist the recipient/employers with the process of completing the Employer's First Report of Occupational Injury (SCIF Form 3167IHSS) and to assure that the injured employee promptly receives an Employee Claim Form.

If you have any questions, please call Mr. William Schimeck at (916) 323-5316.

LOREN D. SUTER
Deputy Director
Adult and Family Services

Attachment

cc: CWDA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

NAME	DATE OF INJURY OR ILLNESS	TIME OF DAY
	/ /	☐ A.M. ☐ P.M.
HOME ADDRESS (Number, Street, City , Zip Code)		
WHERE DID ACCIDENT OR EXPOSURE OCCUR (Number, Street, City, Zip Code)		

DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED

NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

You may be entitled to one or more of the following benefits provided for you at your employer's expense, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of your employer's notice or knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

YOU MUST FILE THIS CLAIM FORM WITH YOUR EMPLOYER TO PROTECT YOUR RIGHTS

Failure to file this claim form will preclude you from receiving any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1/ (415) 557-1954. This service is provided to you at no cost . You also may consult an attorney.

I gave this form to my employer on (date) _____, 19_____.

EMPLOYEE: Keep copy marked "EMPLOYEE'S TEMPORARY RECEIPT " until you receive the dated copy from your employer.

EMPLOYER FILLS OUT THIS PART

Date of knowledge of injury	Date claim form was provided to employee	Date claim form was received
/ /	/ /	/ /
Name of Employer		
Signature of Employer/Representative		

Employer: You are required to date this form and provide copies as marked, to your insurer and to the employee, dependent or agent who filed the claim.
Signing this form does not necessarily constitute acceptance of a claim.
Please return original to your local State Fund office.

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (NEW 1-90)

STATE FUND COPY